MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8320)

08876

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town .....
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 Raspe Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME John George Baier

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ena Hasbrock Baier
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 15, 1875

8. AGE:	Years	Months	Days	If less than one day
	70	8	9	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation Salesman
11. Industry or business ---

FATHER
12. Name Joseph Baier
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Elizabeth Young
15. Birthplace Baltimore, Md.

16. Informant Records of Springfield State Hospital, Sykesville, Md.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 27, 1945 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Belair Road
18. Funeral director Frank V. Pipitone
Address 2818 E. Baltimore St.

19. 9-25 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1945, at 8:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 13 1945, to Sept. 24 1945
and that I last saw h. alive on Sept. 23 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hour
Due to Generalized Arteriosclerosis	
Due to	
Other conditions Psychosis with Cerebral arteriosclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Arnold H. Eibert M.D.
M. D. or other
Address Sykesville Md. Date signed 9-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49a)

CERTIFICATE OF DEATH

08877

Reg. Diat. No. 76

1. PLACE OF DEATH

County: Carroll Co.

City or town: Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 18 Years

Hospital, institution, or street address where death occurred: along the New Windsor Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll Co.

City or town: Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: along the New Windsor Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Florence Whitehill Barnes

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: James G. Barnes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 12 1883

8. AGE:

Years	Months	Days	If less than one day
62	7	10	..... hrs. ..... min.

9. Birthplace: Unionville, Fred Co. Md.

(Town, county, and state)

10. Usual occupation: House-wife

11. Industry or business

FATHER

12. Name: John Whitehill

13. Birthplace: Fred Co. Md

MOTHER

14. Maiden name: Susan Barnes

15. Birthplace: Fred. Co. Md.

18. Informant: Mrs. James G. Barnes

Address: Westminster Md, R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/25/45 (month) (day) (year)

Cemetery or ~~crematory~~: Lutheran Cem.

Location: Unionville Fred Co. Md.

18. Funeral director: J. E. Myers, D.C.

Address: Westminster, Md.

19. 9/24 19 45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 22 1945, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1945 to Sept 22 1945

and that I last saw h.er alive on Sept. 21 1945

Immediate cause of death	DURATION
Leiomyoma of Ovary	yr
general Peritoneal Metastasis	
Due to	
Due to	
Other conditions: Arteriosclerotic C-Disease	

(Includa pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James T. Shook M.D.

M. D. or other

Address: Unionville Md Date signed 9/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 68878

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months, 29 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium, Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1104 Sarah Ann Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HERBERT QUEEN BAY

3.(b) Social Security Number: 217-07-0933

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Mary Bay
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10, 1900

8. AGE:	Years	Months	Days	If less than one day
	45	6	16	hrs. min.

9. Birthplace: Harmon, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/29/45 (month) (day) (year)
Cemetery or crematory: Arbutus M. Park,
Location: Arbutus, Md.
18. Funeral director: Mrs Katie Williams
Address: 322 N. Schroeder St

19. Sept. 26, 19 45 (Date rec'd by registrar)
Albert R. Fernandez Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26, 19 45, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 27, 19 44, to Sept. 26, 19 45
and that I last saw him alive on Sept. 26, 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions: Pulmonary Tuberculosis	Aug. 1944

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 9-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0887 42

Reg. Dist. No. 42

1. PLACE OF DEATH:
County Carroll
City or town Westminster R. D. 1 (Silver Run)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. D. 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma Missouri Agness Beachtel

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 24-1866

8. AGE:

Years	Months	Days	If less than one day
78	9	2	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business In her home

FATHER
12. Name John Beachtel
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Catherine Dutterer
15. Birthplace Carroll Co Md.

16. Informant George Styer
Address Westminster Md. R. D-1

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Sept. 28-1945
(month) (day) (year)
Cemetery or crematory Union Cemetery
Location Silver Run. Md.

18. Funeral director J. W. Little & Son
Address Littlestown, Pa R.D. 1

19. Sept. 27 1945
(Date rec'd by registrar)
Calvin Bankert
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1945, at 12:15 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 24 1945, to Sept. 26 1945
and that I last saw h[illegible] alive on Sept. 26 1945

Immediate cause of death	DURATION
Uremia neoplasm and destruction	5 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dowell B. Cooper M. D. or other
Address Littlestown Pa Date signed 9-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

18880

Reg. Dist. No. 37

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: near Uniontown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: near Uniontown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Paul Edmund Berngen

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
1945	Sept	20	4 hrs. ..... min.

9. Birthplace: near Uniontown (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Harry E. Berngen

13. Birthplace: Md

MOTHER — 14. Maiden name: Pauline Mary Bellinger

15. Birthplace: Md

18. Informant: Harry E. Berngen

Address: Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 20-45 (month) (day) (year)

Cemetery or crematory: Piney Creek Church

Location: near Taneytown

18. Funeral director: Raymond K. Wright

Address: Uniontown Bridge Md

19. Sept 20 1945 (Date rec'd by registrar) Margaret Bingle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 20 1945 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 20 1945, to Sept 20 1945

and that I last saw h. alive on Sept 20 1945

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. N. Bigg M. D. or other

Address: Union Bridge Md Date signed 9-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

08881 81

★ Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie Rosamond Bohn

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife W. Grant Bohn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 18, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	21	..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Albert Koons

13. Birthplace Md.

MOTHER 14. Maiden name Eliza Angell

15. Birthplace M,d.

16. Informant Mr. Frank Bohn

Address Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12, 1945 (month) (day) (year)

Cemetery or crematory Mt. Union Cemetery

Location Nr. Union Bridge, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. Sept 12, 1945 (Date rec'd by registrar) Luke L. Ridd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1945 at 1030 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 1945 to Sept 9 1945

and that I last saw h.. alive on Sept 9 1945

Immediate cause of death Coronary Thrombosis ..... DURATION

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. A. Thomson M.D. M. D. or other

Address Union Bridge Md. Date signed Sept 11 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08882

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Months, 24 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1429 N. Fremont Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: RUTH CARTER BOSTON

3.(b) Social Security Number: 217-22-9003

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 23, 1908

8. AGE: Years	Months	Days	If less than one day
37	0	29	hrs. min.

9. Birthplace: Nuttsville, Va.
(Town, county, and state)
10. Usual occupation: Maid
11. Industry or business: Beauty Shop.

FATHER
12. Name: Lumbert Carter
13. Birthplace: Nuttsville, Va.

MOTHER
14. Maiden name: Maria Bell.
15. Birthplace: Nuttsville, Va.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/24/45 (month) (day) (year)
Cemetery or crematory: Cemetery Loyley
Location: Lancaster Va.
18. Funeral director: Mrs Geo H Holland
Address: 1631 Druid Hill ave

19. 9/21 (Date rec'd by registrar) 19 45 Albert R Greenberg Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21, 1945, at 6.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 1945 to Sept. 21, 1945 and that I last saw her alive on September 21, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1st. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed 9/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

08883

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yr., 7 mo., 22 days

Hospital, institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 12 yr., 7 mo., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Frederick Breckenridge

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 16, 1904

8. AGE: Years	Months	Days	If less than one day
41	2	23	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: clerk

11. Industry or business

FATHER — 12. Name: James Thomas Breckenridge

13. Birthplace: Baltimore City, Maryland

MOTHER — 14. Maiden name: Catherine Margaret Gempp

15. Birthplace: Maryland

16. Informant: SPRINGFIELD STATE HOSPITAL RECORDS

Address: SYKESVILLE, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12, 1945 (month) (day) (year)

Cemetery or crematory: Western

Location: Balto. Md.

18. Funeral director: George W. Little

Address: 2700 Edmondson Ave.

19. 9-10 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9 19 45, at 3:36p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43, to Sept. 9 19 45

and that I last saw him alive on September 9 19 45

Immediate cause of death	DURATION
Coronary occlusion	15 min.
Due to	
Due to	
Other conditions: Dementia precox, paranoid type	14 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other

SPRINGFIELD STATE HOSPITAL
Address: SYKESVILLE, MARYLAND Date signed 9-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08884

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 28 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne's
City or town: Centreville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: THOMAS SHERMAN BROWN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife: Harriet Brown
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): April 11, 1888

8. AGE: Years	Months	Days	If less than one day
57	4	29	hrs. min.

9. Birthplace: Centreville, Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Thomas Brown
13. Birthplace: Centreville, Md.

MOTHER
14. Maiden name: Carrie Rines
15. Birthplace: Centreville, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept-12-1945 (month) (day) (year)
Cemetery or crematory:
Location: Brownsville, Md
18. Funeral director: Mrs. F. Hensley
Address: 578 W. Biddle St.

19. 9/9 (Date rec'd by registrar) 1945 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9, 1945, at 1.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept., 12, 1944, to Sept., 9, 1945 and that I last saw h... alive on Sept., 9, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: June 1944

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Md Date signed: 9/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08885

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 26 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Preston
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. #2, Box 80
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES HENRY BUTLER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Viola Butler
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): June 15, 1889

8. AGE:	Years	Months	Days	If less than one day
	56	2	23	...hrs. ...min.

9. Birthplace: Preston, Maryland (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER — 12. Name: William Butler
FATHER — 13. Birthplace: Preston, Maryland
MOTHER — 14. Maiden name: Alice Nicholson
MOTHER — 15. Birthplace: Preston, Maryland
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/11/45 (month) (day) (year)
Cemetery or crematory: Jamestown Cemetery
Location: near Preston, Md.
18. Funeral director: J. J. Frampton
Address: Federalsburg, Md.
19. Sept. 7, 1945 (Date rec'd by registrar) Albert A. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7, 1945 at 8:05 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 11, 1945 to Sept. 7, 1945 and that I last saw him alive on September 7, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. (M. D. or other)
Address: Henryton, Maryland Date signed: 9-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

08886

★ Reg. Diat. No. 74

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 22 days

Hospital, Institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 5 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4808 Battery Lane
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Edward V. Caywood

3. (b) Social Security Number: 218-20-2256

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	married

6.(b) Name of husband or wife: Julia

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 8, 1869

8. AGE: Years	Months	Days	If less than one day
75	11	11	..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: night watchman

11. Industry or business:

FATHER
12. Name: Samuel Caywood
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Wells
15. Birthplace: Virginia

16. Informant: SPRINGFIELD STATE HOSPITAL RECORDS
Address: SYKESVILLE, MARYLAND

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 19, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Bethesda, Md.

18. Funeral director: Wm Reuben Pumphrey
Address: Bethesda, Md.

19. Sept 19 1945 (Date rec'd by registrar) C. Henry Wiese Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 1945 at 1:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3 1945 to Sept. 19 1945 and that I last saw him alive on September 18 1945

Immediate cause of death	DURATION
Arteriosclerosis, prior to	1945
Due to	
Due to	
Psychosis with disturbance of	
Other conditions circulation - cardio-	
renal disease	2 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robert Bertrand May M.D.
SPRINGFIELD STATE HOSPITAL M.D. or other
Address: SYKESVILLE, MARYLAND Date signed: 9-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37)

CERTIFICATE OF DEATH

08887

Reg. Dist. No. 207

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Plesant Valley
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Plesant Valley
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Charles Elsworth Copenhaver

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Annie Copenhaver

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 12, 1867

8. AGE: Years	Months	Days	If less than one day
78	5	21	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: Isaiah Copenhaver

13. Birthplace: Md.

MOTHER 14. Maiden name: Elizabeth Eckard

15. Birthplace: Md.

16. Informant: Mrs. Vernon Myers

Address: Pleasant Valley, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: September 6, 1945 (month) (day) (year)

Cemetery or crematory: Baust Church Cemetery

Location: Tyrone, Md.

18. Funeral director: C.O. FUSS & SON

Address: Taneytown, Md.

19. Sept 5 1945 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 3rd 1945 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1945 to Sept 1st 1945 and that I last saw him alive on Sept 1st 1945

Immediate cause of death	DURATION
Uremia	
Due to: Mal Nutrition	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John J Stonesifer M. D. or other

Address: Westminster Md Date signed: Sept 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08888

★ Reg. Diat. No. 83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Woodbine

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Woodbine

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Roland Theodore Crabb

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

B.(b) Name of husband or wife none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1945

8. AGE: Years	Months	Days	If less than one day
		11	..... hrs. ..... min.

9. Birthplace Woodbine, Md. (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Roland Winfield Crabb

13. Birthplace Maryland

MOTHER 14. Maiden name Ida May Hatfield

15. Birthplace Maryland

16. Informant Roland W. Crabb

Address Woodbine, Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 9-20-45 (month) (day) (year)

Cemetery ~~or crematory~~ Poplar Springs

Location Poplar Springs, Howard Co. Md.

18. Funeral director C. M. Wells

Address Winfield, Md.

19. Sept 19 1945 Eva M Hewitt Deputy Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1945 19..... at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 7, 1945 19..... to Sept 18th 19.....

and that I last saw him alive on Sept. 17, 1945 19.....

Immediate cause of death Atelectasis — DURATION 11 da

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations none ..... Date of op. .....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Stanley Grabill M. D. or other

Address Woodbine, Md Date signed 9/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

08889

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Central Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George Thomas Davis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Agnes A. Brown

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 5, 1871

8. AGE: Years	Months	Days	If less than one day
74	1	20	..... hrs. ..... min.

9. Birthplace: Frederick County, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Unk - Davis

FATHER — 13. Birthplace: Unk. -

MOTHER — 14. Maiden name: Unk -

MOTHER — 15. Birthplace: Unk -

16. Informant: Mrs. Agnes A. Davis

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-28-45 (month) (day) (year)

Cemetery or crematory: Western Cemetery

Location: Balto., Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Sept. 26 1945 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25 1945, at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1945 to Sept 25 1945

and that I last saw him alive on Sept 22nd 1945

Immediate cause of death	DURATION
Cardio Vascular Disease	
Due to	
Due to	
Other conditions	

(Iociode pregnancy within 3 months of death)

Major findiogs of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please uoderline the caose to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. A. Barnes M.D.
M. D. or other

Address: Sykesville Md. Date signed 9/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9429)

CERTIFICATE OF DEATH

08890

Reg. Dist. No. 70

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Baltimore St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: R. Mc Clure Dayhoff

3.(b) Social Security Number: 212-03-0499

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 29, 1912

8. AGE:

Years	Months	Days	If less than one day
33	7	29	hrs. min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)

10. Usual occupation: Inspector

11. Industry or business: Dairy

FATHER 12. Name: Raymond A. Dayhoff

13. Birthplace: Md.

MOTHER 14. Maiden name: Rhoda D. Bowersox

15. Birthplace: Md.

16. Informant: Mrs. Rhoda Dayhoff

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 1, 1945 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Uniontown, Md.

18. Funeral director: C. O. Guss & Son

Address: Taneytown, Md.

19. Sept 30. 19 45 - Ethel M. Mehring

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28 1945 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Occlusion	10 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Monk Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed: 9/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 08894

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs., 10 mo., 6 days

Hospital, Institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 20 yrs., 10 mo., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: Baltimore City

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Joseph M. Diven

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 12, 1864

8. AGE: Years	Months	Days	If less than one day
77 (?) 81	6	7	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business:

FATHER
12. Name: Edward Thomas Diven
13. Birthplace: Balto. Md.

MOTHER
14. Maiden name: Elizabeth McCoy
15. Birthplace: Balto. Md.

16. Informant: SPRINGFIELD STATE HOSPITAL RECORDS
Address: SYKESVILLE, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-22-45 (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: Balto. Md.

18. Funeral director: Wm Bergman & Son

Address: Reisterstown, Md.

19. Sept 19 1945 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 1945 at 7:25a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Sept. 19 1945 and that I last saw him alive on September 18 1945

Immediate cause of death	DURATION
Arteriosclerosis	12 yrs.
Due to	
Due to	
Other conditions: Senile psychosis, simple deterioration	24 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
SPRINGFIELD STATE HOSPITAL M. D. or other
Address: SYKESVILLE, MARYLAND Date signed: 9-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

08892

CERTIFICATE OF DEATH

Reg. Dist. No. 81.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Veritas Jenassa Eakle

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Martin W. Eakle

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 1, 1883

8. AGE: Years	Months	Days	If less than one day
62	8	18	hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: housework

11. Industry or business

FATHER — 12. Name: Theodore Fowble

13. Birthplace: Md

MOTHER — 14. Maiden name: Anna I. Graham

15. Birthplace: Md.

16. Informant: Mrs. Frank P. Bohn

Address: Union Bridge, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 21, 1945 (month) (day) (year)

Cemetery or crematory: Keedysville

Location: Keedysville, Md.

18. Funeral director: C.O. FUSS & SON

Address: Taneytown, Md.

19. Sept 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 1945, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1945 to Sept 19 1945

and that I last saw h[illegible] alive on Sept. 19 1945

Immediate cause of death	DURATION
(a) Carcinoma of uterus	100 d.
Due to: (b) Hypertensive cardiovascular disease	2-3 yrs.
Due to:	
Other conditions: Gen. arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. L. Seigman M. D. or other

Address: Union Bridge, Md. Date signed: 9/19/45

08893

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 N. Vincent Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: PERCY GODWIN

3.(b) Social Security Number: 243-26-3925

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married (Sep.)

6.(b) Name of husband or wife: Margaret Godwin 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 5, 1923

8. AGE: Years	Months	Days	If less than one day
22	6	19	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Oiler

11. Industry or business

FATHER — 12. Name: Yank Hastings
13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Roberta Godwin
15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 9/25/45 (month) (day) (year)

Cemetery or crematory:
Location: Selma N.C.

18. Funeral director: Mrs Katie R. Williams
Address: 322 N. Schroeder St

19. Sept. 24, 45 (Date rec'd by registrar) Albert A. Swackhamer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24, 1945 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 12, 1945 to Sept. 24, 1945 and that I last saw him alive on Sept. 24, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 9-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46a)

CERTIFICATE OF DEATH

08894

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 80 E. Main

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Henry Harman

3. (b) Social Security Number 219-20-4729

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Carrie M. Wilhide

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Oct. 26 - 1871

8. AGE:

Years	Months	Days	If less than one day
73	10	24	....hrs. ....min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Dealer in furniture

11. Industry or business Retired

FATHER 12. Name Samuel Francis Harman

FATHER 13. Birthplace Pa.

MOTHER 14. Maiden name Sarah Fisher

MOTHER 15. Birthplace Carroll Co. Md.

16. Informant Mary Agnes Harman

Address 80 E. Main, Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 24-1945 (month) (day) (year)

Cemetery or crematory Westminster Cem.

Location Westminster, Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 9/22 19 45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1945 at 30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1941, to Sept 20 - 1945 and that I last saw h... alive on Sept. 20 - 1945

Immediate cause of death	DURATION
Carcinoma (esophagus)	
Myocarditis (chr)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Bennett M.D.
M. D. or other

Address Westminster, Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0874 5

PLEASE WRITE PLAINLY, WITH UNFADING INK: Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 yrs., 2 mos., 25 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 11 yrs., 2 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Not known (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Joseph Henderson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ----
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 21, 1874

8. AGE:

Years	Months	Days	If less than one day
71	5	2	hrs. min.

9. Birthplace: Govanstown, Md. (Town, county, and state)
10. Usual occupation: Salesman & Laborer
11. Industry or business: ----

FATHER
12. Name: Joseph A. Henderson
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Laura B. Lane
15. Birthplace: New York, N. Y.

16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address:

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept. 25 1945 (month) (day) (year)
Cemetery or crematory: Springfield Hospital Cem.
Location: Sykesville, Md.

18. Funeral director: C. Harry Eiler
Address: Sykesville, Md.

19. Sept. 25 1945 C. Harry Eiler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23 1945 at 8:30a.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1938, to Sept. 23 1945
and that I last saw him alive on Sept. 23 1945

Immediate cause of death	DURATION
Bronchio-pneumonia	3 days
Due to	
Due to	
Other conditions Contributing Somatic Disease	7 yrs.
Pulmonary Tuberculosis	7 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arnold V. Eisert M.D. M. D. or other
Address: S. S. Hosp. Sykesville Md. Date signed 9-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08896

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hemryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 4 mo., 1 day
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Hemryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2531 Salem Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM HOLMES

3.(b) Social Security Number: 213-01-4427

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Iva Peggy Holmes

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12, 1904

8. AGE:	Years	Months	Days	If less than one day
	41	1	22	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Labbrer

11. Industry or business:

FATHER
12. Name: Guy Holmes
13. Birthplace: Virginia

MOTHER
14. Maiden name: Nettie Fletcher
15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M. D.
Address: Hemryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-6-45 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemety
Location: a. a. Co. md.

18. Funeral director: William a Jackson
Address: 916 Penn Ave

19. 9/3 (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3, 19 45, at 5.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2, 7, 19 44 to Sept. 3, 19 45 and that I last saw him alive on September 3, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1941
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Hemryton, Md. Date signed: 9/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08897

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 21 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1816 Lorman Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: VIRGINIA HORSEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10, 1927

8. AGE: Years	Months	Days	If less than one day
18	3	17	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: Albert Horsey

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Jane Smith

MOTHER — 15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct-1-45 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Arundel Co.

18. Funeral director: Geo. G. Kelson

Address: 1303 Preston St.

19. Sept. 27, 1945 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27, 1945, at 5:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6, 1945, to Sept. 27, 1945 and that I last saw her alive on September 27, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 9-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

08898

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Idellia K Houck

3.(b) Social Security Number: c

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Daniel W Houck
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Feb 6 1873

8. AGE: Years	Months	Days	If less than one day
72	7	5	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John S Stricklin
13. Birthplace: Md

MOTHER
14. Maiden name: Eliza A Metz
15. Birthplace: Md

16. Informant: Mrs Morris Miller
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 14/45 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Greenmount, Md
18. Funeral director: Edw C Tipton
Address: Hampstead, Md

19. Sept 13 (Date rec'd by registrar) 1945 John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 11 1945 at 4:55 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1945, to Sept. 11 1945
and that I last saw h-- alive on Sept. 10 1945

Immediate cause of death	DURATION
Abdominal Carcinomatosis	3 mo.
Due to: Carcinoma of Cecum	5 mo.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Dannie C. Partenfield
M. D. or other
Address: Hampstead Md Date signed: 9-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

0899

Reg. Dist. No. 79

1. PLACE OF DEATH:
County: Carroll
City or town: Detour - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Months
Hospital, institution, or street address where death occurred:
Near Detour
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Detour - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Near Detour
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: SUSIE ELIZABETH HOUCK

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Daniel E. Houck
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 29, 1863

8. AGE: Years	Months	Days	If less than one day
81	10	5	..... hrs. ..... min.

8. Birthplace: Libertytown-Frederick-Maryland
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business
FATHER 12. Name: Jonas E. Kerglo
FATHER 13. Birthplace: Penna.
MOTHER 14. Maiden name: Mary Root
MOTHER 15. Birthplace: Frederick County Maryland
16. Informant: Mrs. Clarence C. Burrier
Address: Detour, Maryland - Rural
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/6/45 (month) (day) (year)
Cemetery or crematory: Mount Olivet Cemetery
Location: Frederick, Maryland
18. Funeral director: M. R. Etchison and Son
Address: Frederick, Maryland
19. 4-Sept 1945 (Date rec'd by registrar) Fanny M. Kiser 9/13/45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 4 1945, at 4 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-1 1945, to 9-4-1945
and that I last saw h... alive on 9-3-45 1945

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. N. Legg M. D.
M. D. or other
Address: Mercersburg, Pa. Date signed: 9-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

08900

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 - 5 - 12

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Howard Milton Hyle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Ida Baumgardner Hyle

6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Dec. 23 - 1869

8. AGE: Years 75 | Months 8 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Contractor

11. Industry or business Concrete work

FATHER 12. Name John C Hyle

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Helen Deardorff

MOTHER 15. Birthplace Md.

16. Informant C Parker R. Hyle

Address Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 15 1945 (month) (day) (year)

Cemetery or crematory Reindeer Cem.

Location Westminster Md.

18. Funeral director A Bankard & Son

Address Westminster, Md.

19. 9/13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1945 at 6:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Fractured skull	
Comp. fracture left forearm	
Due to Fracture left leg	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-12-45

Where did injury occur? Mt. Pleasant Carroll Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route 140

Means of injury Struck by automobile Injured at work? No

23. SIGNATURE James T. Ward, Deputy Medical Examiner M. D. or other

Address Westminster Md. Date signed 9/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08901

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 345½ Forrest Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ELEANORA JACKSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 8, 1926

8. AGE:	Years	Months	Days	If less than one day
	18	9	16	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Dallas Jackson
13. Birthplace: Florida

MOTHER
14. Maiden name: Mattie ?
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial, cremation, or removal. Which? Burial Date thereof 9/27/45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location:
18. Funeral director: Elroy D. Wilson
Address: 1000 Brantley Ave

19. Sept. 27, 1945 (Date rec'd by registrar) Albert R. Lumsden Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24, 1945 at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25, 1945 to Sept. 24, 1945 and that I last saw her alive on Sept. 24, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Maryland Date signed: 9-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20)

08902

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 14 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 817 N. Fremont Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SADIE ELIZABETH JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1925

8. AGE:	Years	Months	Days	If less than one day
	20	6	19.	hrs. min.

9. Birthplace: Petersburg, Va.
(Town, county, and state)
10. Usual occupation: Packer
11. Industry or business

FATHER
12. Name: Alfred Johnson
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mamie Anderson
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-23-45 (month) (day) (year)
Cemetery or crematory: Eastern
Location: Petersburg Va
18. Funeral director: J. A. Jackson
Address: Petersburg Va

19. Sept. 20, 19 45 (Date rec'd by registrar) Robert A. Swanblom Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20, 1945 at 9:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6, 1945 to September 20, 1945 and that I last saw her alive on Sept. 20, 1945

Immediate cause of death	DURATION
Miliary Tuberculosis	July 1945
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Maryland Date signed 9-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

08903

★ Reg. Diat. No. 81.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Linwood-McKinstrys Road

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Joseph Wilson Jones

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Zanie Myers Jones

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1855

8. AGE:	Years	Months	Days	If less than one day
	90	-	-	..... hrs. ..... min.

9. Birthplace: Carroll County Maryland (Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business: Self-Employed

FATHER — 12. Name: Thomas Jones

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Becky Burkett

MOTHER — 15. Birthplace: Maryland

16. Informant: Daniel W Jones

Address: Union Bridge Md R 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29-1945 (month) (day) (year)

Cemetery or crematory: Western Chapel Cemetery

Location: near Westminster Maryland

18. Funeral director: D.D.Hartzler & Sons

Address: Union Bridge & New Windsor Md

19. Sept. 28, 1945 (Date rec'd by registrar) E. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 27 1945, at 3:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 22 1945, to Sept 27 1945

and that I last saw h.. alive on Sept 27 1945

Immediate cause of death: Heart failure, acute — DURATION: 2-3 (1)

Due to: Arteriosclerotic cardiac degeneration

Due to:

Other conditions: Pneumonia, generalized arteriosclerosis, senility

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. L. Seigman M. D.

Address: Union Bridge, Md. Date signed: 9/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08904

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 5 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 526 Oxford Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MARY JONES

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 1, 1921

8. AGE:	Years	Months	Days	If less than one day
	24	2	6	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: Ernest Jones

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Elizabeth Johnson

MOTHER — 15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 10, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore City

18. Funeral director: Geo. G. Kelson

Address: 1303 Arrestman St.

19. 9/7 1945 (Date rec'd by registrar) Albert R. Swarbrick Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7, 1945, at 6.40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2, 1945, to Sept., 7 1945 and that I last saw her alive on September 7, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 9/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

08905

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Over 1 yr

Hospital, institution, or street address (if not in hospital) Springfield State Hospital

How long in hospital or institution? Over 1 yr

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 743 n Montford Ave
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Anna Catherine Kemp

3.(b) Social Security Number -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Charles Kemp.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 12 - 1873

8. AGE: Years 72 | Months 7 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Balto Co.
(Town, county and state)

10. Usual occupation Housewife

11. Industry or business At home

FATHER 12. Name Valentine Stoller.

13. Birthplace Maryland.

MOTHER 14. Maiden name Mary Teresa Tyering

15. Birthplace Maryland

16. Informant Mrs Olivia H Kemp.
Address 743 n montford Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/29/45 (month) (day) (year)

Cemetery or crematory Parkwood

Location Taylor Avenue

18. Funeral director John C. Miller Inc.

Address 2435 E. Oliver Street

19. 9-28-45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 th 19 45 at 8-15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1945 to Sept 26 1945

and that I last saw h.e alive on Sept 26 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	3 da
Due to	
Due to Chronic Arteriosclerosis	10 yrs
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J J Gaston M.D.
M. D. or other

Address Sykesville Md Date signed 9/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08906

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 9 mo. 18 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium, Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 442 W. Biddle St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WADE GADDY LITTLE

3.(b) Social Security Number: 239-05-4944

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 7, 1907

8. AGE:	Years	Months	Days	If less than one day
	38	0	11	hrs. min.

9. Birthplace: Wadesboro, N.C. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Jim Little
13. Birthplace: Wadesboro, N.C.

MOTHER
14. Maiden name: Lula Gaddy
15. Birthplace: Wadesboro, N.C.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 20, 1945 (month) (day) (year)
Cemetery or crematory: Fade
Location: North Carolina
18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Ave.

19. Sept. 18, 1945 (Date rec'd by registrar) Albert Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18, 1945, at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 30, 1943, to Sept. 18, 1945 and that I last saw him alive on September 18, 1945

Immediate cause of death	DURATION
Tuberculous Meningitis	8-18-45
Due to: Pulmonary Tuberculosis	10-19-43
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 9-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08907

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (d)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Marylamd County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary McDonald

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 29th, 1857

8. AGE: Years	Months	Days	If less than one day
88	2	12	hrs. min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: NONe
11. Industry or business

FATHER
12. Name: Matthew Mc.Donald
13. Birthplace: Unknown

MOTHER
14. Maiden name: Catherine Lennon
15. Birthplace: Unknown

16. Informant: Mrs. Howard Scott
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-13-45 (month) (day) (year)
Cemetery or crematory: St. Joseph's Cemetery
Location: Sykesville, Md.

18. Funeral director: C. Harry Weer
Address: Sykesville, Md.

19. 9-11-45 (Date rec'd by registrar) 19 C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 10th, 1945 19 3-3.0 P.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 42 to Sept 10 19 45
and that I last saw h alive on Sept 9 19 45

Immediate cause of death: Uraemia — Hypertensive Renal Disease

	DURATION
Due to	
Due to	
Other conditions: Contracted Foot Leg	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. H. Barnes M.D. M. D. or Coroner
Address: Sykesville Md. Date signed 9/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

08908

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md. (Rural).
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yrs., 8 mos., 5 days.
Hospital, institution, or street address where death occurred:
Springfield State Hospital.
How long in hospital or institution? 17 yrs., 8 mos., 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3207 Belmont Ave., Howard Park.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Thomas Bond Poisal.

3.(b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): August 9, 1878.

8. AGE: Years	Months	Days	If less than one day
67.	2.	15.	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county and state)
10. Usual occupation: Delivery man.
11. Industry or business: Dairy.
FATHER 12. Name: Thomas B. Poisal.
FATHER 13. Birthplace: Maryland.
MOTHER 14. Maiden name: Eliza J. Foster.
MOTHER 15. Birthplace: Maryland.
16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-27-45 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Balto. Md.
19. Funeral director: William Cook Inc.
Address: 1217 St. Paul st
19. Sept 25 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24, 1945, at 1.05 p. m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1936, to Sept. 24 1945, and that I last saw h. i.m. alive on September 24 1945.

Immediate cause of death	DURATION
Arteriosclerosis with Hypertension-prior to	1-19-'28.
Due to:	
Due to:	
Other conditions: Psychosis c. Mental Deficiency — prior to (Include pregnancy within 3 months of death)	1-1928.

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D., M. D. or other
Address: Sykesville, Md. Date signed 9-24-'45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-2)

CERTIFICATE OF DEATH

08969

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Eastview

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Eastview

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. Westminster

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: THOMAS S. POOLE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife: Mary A. Poole

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): April 14, 1865

8. AGE: Years	Months	Days	If less than one day
80	5	6	...hrs. ...min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: John H. Poole

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth C. Murray

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Mary A. Poole

Address: Westminster, Md.

17. Burial (Burial, ~~cremation~~, or removal, which?) Date thereof: 9-24-45 (mooth) (day) (year)

Cemetery ~~or crematory~~: Providence

Location: Gamber, Carroll Co. Maryland

18. Funeral director: C.M.Waltz

Address: Winfield, Md.

19. 9 30 19 45 (Date rec'd by registrar) L. L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 20, 1945, at 12;10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1942 to Sept 20 - 1945

and that I last saw h.~~im~~ alive on Sept 20 1945

Immediate cause of death	DURATION
Carcinoma (voluntary)	
Myocarditis (chr)	
Nephritis (chr)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? None (City or town) (Cooty) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. C. Jamette M.D. M. D. or other

Address: Westminster Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

68910

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (159)

County Carroll — Registration Dist. No. 76

Village or City Westminster Md — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. 1hr 20m mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Baby Boy Reaver

(a) Residence: No. 238 E main St., Ward. Westminster Md

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day, and year) September 19 1945

7. AGE

Years	Months	Days	If LESS than 1 day, ____ hrs. or 20 min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and yaar) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Westminster Md
(State or country) Md

FATHER

13. NAME Earl R Reaver

14. BIRTHPLACE (city or town) Frederick Co
(State or country) Md.

MOTHER

15. MAIDEN NAME Brawner

16. BIRTHPLACE (city or town) Frederick Co
(State or country) Md

17. INFORMANT Ruth Reaver
(Address) Littlestown Pa RD #1

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Repose Cem Date 9/20, 1945

19. UNDERTAKER Earl Haines
(Address) Littlestown Pa

20. FILED 9/20, 1945 [signature]
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH September (Month) 19 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept 19, 1945, to Sept 19, 1945

I last saw h alive on Sept 19, 1945; death is said to have occurred on the date stated above, at 8:30 p.m.

The **PRINCIPAL CAUSE OF DEATH** and related causas of importance were es follows:

	Date of onset
Premature	
Other **Contributory Causes** of importance:	

Nama of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19____

Where did injury occur? ____
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way ralated to occupation of deceased? ____

If so, specify ____

(Signed) W Glenn Speicher M. D.

(Address) Westminster Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

STATE OF MARYLAND—CERTIFICATE OF DEATH

08911

1. PLACE OF DEATH

County Carroll (151) Registration Dist. No. 76

Village or City Westminster No. 20 Main No. 238 E Main St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residance in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Baby Boy Reaver

(a) Residence: No. 238 E Main St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Sept 9/45

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
				2 hrs.

OCCUPATION

8. Trade, profession, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was dona, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and yaar)

11. Total tima (years) spent in this occupetion

12. BIRTHPLACE (city or town)
(State or country)

FATHER

13. NAME Earl Reaver

14. BIRTHPLACE (city or town)
(State or country) Md

MOTHER

15. MAIDEN NAME [redacted]

16. BIRTHPLACE (city or town)
(State or country) Md

17. INFORMANT Earl Reaver
(Address) Littlestown R D 1

18. BURIAL, CREMATION, OR REMOVAL
Place O M Palmer's Date 9/20, 1945

19. UNDERTAKER Earl Reaver
(Address) Littlestown Pa R D 1

20. FILED 9/20, 1945 L Kowandner
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH September 19, 1945
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from September 19 1945, to Sept 19, 1945
I last saw h... alive on Sept 19, 19..., death is said to hava occurred on the data stated above, at 9:20 a.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Prematurity	

Other **Contribntory Causes** of importance:

Name of operation ... Data of ...

What test confirmed diagnosis? ... Was there an au'opsy?

23. If death was dua to external causes (VIOLENCE) fill in also tha following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) W. Glenn Spencher M. D.

(Address) Westminster Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08912

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 23 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 780 W. Saratoga Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LORELL MASON REED

3.(b) Social Security Number: 223-03-0369

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: Moses Reed
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 6, 1912

8. AGE:	Years	Months	Days	If less than one day
	22	10	19	hrs. min.

9. Birthplace: Richmond, Virginia (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Benjamin Mason, Sr.
13. Birthplace: Mountson, North Carolina

MOTHER
14. Maiden name: Nora Meade
15. Birthplace: Richmond, Va.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 9/25/45 (month) (day) (year)
Cemetery or crematory: Murray's Cemetery
Location: Richmond, Va.
18. Funeral director: E. W. Chase
Address: 628 N. Gilmor St.

19. Sept. 25, 1945 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25, 1945 at 12:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2, 1945 to Sept. 25, 1945 and that I last saw her alive on September 25, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1, 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 9-25-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Addition of mother's 2d name:
Aff. of son JAMES F. RICH
filmed G99 10-30-45 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08913

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)
State: Md. County: Caroline
City or town: Denton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 403 Lincoln St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOHN DOUGLAS RICH

3.(b) Social Security Number: 217-16-9010

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widowed

6.(b) Name of husband or wife: Unk.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 1, 1907

8. AGE:	Years	Months	Days	If less than one day
	38	7.	13	..... hrs. ..... min.

9. Birthplace: Denton, Md.
(Town, county, and state)
10. Usual occupation: Welder
11. Industry or business

FATHER
12. Name: John Henry Rich
13. Birthplace: Denton, Maryland

MOTHER
14. Maiden name: Sarah Elizabeth Sullivan
15. Birthplace: Denton, Maryland

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 17-1945 (month) (day) (year)
Cemetery or crematory: Denton
Location: Denton md
18. Funeral director: James F. Stuart
Address: Salisbury md

19. Sept. 14, 1945 (Date rec'd by registrar)
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14, 1945 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27, 1945, to Sept. 14, 1945 and that I last saw him alive on September 14, 1945

Immediate cause of death	DURATION
Miliary Tuberculosis	March 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 9-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08914

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Taylorsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Taylorsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Westminster
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MRS. WILLA E. RIGLER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: George Rigler
deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 10, 1867

8. AGE: Years	Months	Days	If less than one day
78	1	9	hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Wesley J. Harn
13. Birthplace: Maryland

MOTHER
14. Maiden name: Erith Manahan
15. Birthplace: Maryland

16. Informant: Miss Eloise Frizzell
Address: Westminster, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof: 9-21-45 (month) (day) (year)
Cemetery or ~~crematory~~: Taylorsville
Location: Taylorsville, Carroll Co., Md.

18. Funeral director: C.M. Waltz
Address: Winfield, Md.

19. Sept 20 1945 (Date rec'd by registrar) E. M. Farver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 19, 1945 at 6:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1943 to Sept 19 1945 and that I last saw her alive on Sept 12 1945

Immediate cause of death: Hypertensive C-V disease — Duration: 4 yrs.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Shreve M. D. or other
Address: Westminster Md. Date signed: 9/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08915

CERTIFICATE OF DEATH

★ Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 21 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Street
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: GLADYS SCHOATE

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Arthur Choate
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): November 6, 1917

8. AGE:	Years	Months	Days	If less than one day
	27	10	5	....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Henry Robinson
13. Birthplace: Forest Hill, Md.

MOTHER
14. Maiden name: Lillie Bradford
15. Birthplace: Forest Hill, Md.

16. Informant: Reuben Hoffman, Md.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 14 1945 (month) (day) (year)
Cemetery or crematory: Fairview
Location: Forest Hill, Harford Co. Md.

18. Funeral director: Martin F. Kurtz
Address: Jarrettsville Md

19. Sept. 11, 1945 (Date rec'd by registrar) Albert R. Swan Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11, 1945 at 5:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20, 1945 to Sept. 11, 1945 and that I last saw her alive on September 11, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 15, 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op.
Autopsy results:
PHYSICIAN: Please nodertioe the caose to which death shoold be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (Conoty) (Stote)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Maryland Date signed: 9-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

08916

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Francis Sharrer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 22, 1880

8. AGE: Years	Months	Days	If less than one day
65	7	5	..... hrs. ..... min.

9. Birthplace: Westminster, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: ---

FATHER — 12. Name: George E. Sharrer

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah Cook

MOTHER — 15. Birthplace: Pennsylvania

16. Informant: Records of Springfield State

Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-29-45 (month) (day) (year)

Cemetery or crematory: Westminster

Location: Westminster Md.

18. Funeral director: J. F. Reese

Address: Westminster Md.

19. Sept. 27 1945 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 27 1945, at 1:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 1945 to Sept. 27 1945 and that I last saw him alive on Sept. 27, 1945

Immediate cause of death	DURATION
Chronic Myocarditis	2
Due to Generalized Arteriosclerosis	1
Due to	
Other conditions Senile Psychosis	2

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Arnold H. Eckert M.D. M. D. or other

Address: St. Hosp. Sykesville Md. Date signed 9-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

18917

Reg. Dist. No. 77

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 59 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah Elizabeth Snyder.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: Chas. Andrew Snyder.
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): January 29, 1862.

8. AGE: Years	Months	Days	If less than one day
83	7	10	hrs. min.

9. Birthplace: Sperryville-Balto Co. Md.
(Town, coooty, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Samuel Miller
13. Birthplace: Md
MOTHER 14. Maiden name: Rachael Ann Crowther
15. Birthplace: Md.
18. Informant: John S. Snyder
Address: Hampstead, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9/45 (month) (day) (year)
Cemetery or crematory: Hampstead
Location: Hampstead. Md
18. Funeral director: Edw C Tipton
Address: Hampstead Md
19. Sept 8 1945 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6. 19 45, at 11:10 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 12 19 39, to Sept 6 19 45
and that I last saw h.. alive on Sept 6. 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Generalized arterio-Sclerosis	
Due to:	
Other conditions: Hughes Zoster.	7-8-45

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: Jack E. Buchman M. D. or other
Address: Hampstead Md Date signed 9-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08918

Reg. Diat. No. 77

1. PLACE OF DEATH:
County Carroll
City or town Hampstead (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Hampstead (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ida Lola Stockdale

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife John Stockdale
6.(c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) Dec 22- 1879

8. AGE: Years	Months	Days	If less than one day
65	9	—	...hrs. ...min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Wm. H. Richards
13. Birthplace Md
MOTHER 14. Maiden name Amanda Boone
15. Birthplace Md
16. Informant Mr John Stockdale
Address Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 25/45 (month) (day) (year)
Cemetery or crematory St Pauls
Location Arcadia, Md
18. Funeral director Edw C Tipton
Address Hampstead Md
19. Sept 25 1945 John S. Hughes Jr (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1945 at 5:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23- 1945, to Sept 22 1945
and that I last saw her alive on Sept 22 1945
Immediate cause of death Carcinoma of uterus with hemorrhaging — DURATION
Due to Chronic myocarditis
Due to Thyroid toxemia
Due to Duration and vomiting
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Cyril E. Fowble M.D.
M. D. or other
Address Upperco, Md. Date signed 9/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08919

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Ridgeville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margie Virginia Thomas

3.(b) Social Security Number:

4. Sex: F
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: John C. Thomas
6.(c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): Jan. 29 1898
8. AGE: Years: 47 Months: 7 Days: 7 If less than one day: hrs. min.
9. Birthplace: Frederick Co.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:
FATHER 12. Name: Frank Taylor
13. Birthplace: Montgomery Co.
MOTHER 14. Maiden name: Carrie Biggur
15. Birthplace: Carroll Co.
16. Informant: John C. Thomas
Address: Mt. Airy Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9 1945 (month) (day) (year)
Cemetery or crematory: Friendship
Location: Near Damascus
18. Funeral director: H. M. Snyder
Address: Mt. Airy, Md.
19. Sept. 7 1945 (Date rec'd by registrar) Hmd Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1945, at 11 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 1944 to Sept 5 1945
and that I last saw her alive on Sept 4 1945
Immediate cause of death: Cerebral Hemorrhage — DURATION: 1 week
Due to: Arteria sclerosis — 5 yrs
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ernest P. Roop M.D. M. D. or Other
Address: New Market Md Date signed: Sept 5/45

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08920

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 18 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Geo's
City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
JAMES RUSSELL WASHINGTON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1928

8. AGE: Years	Months	Days	If less than one day
17	3	14	hrs. min.

9. Birthplace Upper Marlboro, Md.
(Town, county, and state)
10. Usual occupation Scholar
11. Industry or business at school
FATHER 12. Name James Washington
13. Birthplace Unknown
MOTHER 14. Maiden name Lillie Bell
15. Birthplace Upper Marlboro, Md.
16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 13 45 (month) (day) (year)
Cemetery or crematory Upper Marlboro Md
Location Upper Marlboro Md
18. Funeral director Gutchins Bros
Address Upper Marlboro Md
19. 9/10 (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 19 45 at 3.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 23, 19 45 to Sept., 10 19 45 and that I last saw him alive on September 10, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please noderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M. D.
M. D. or other
Address Henryton, Md. Date signed 9/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

8921

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Street
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
CHARLES EDWARD WATERS

3.(b) Social Security Number
218-05-2856

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan., 19, 1905

8. AGE: Years	Months	Days	If less than one day
40	7	12	hrs. min.

9. Birthplace Street, Md.
(Town, county, and state)
10. Usual occupation Filling Station Operator
11. Industry or business
FATHER 12. Name Walter Waters
13. Birthplace Street, Md.
MOTHER 14. Maiden name Margaret Kenley
15. Birthplace Street, Md.
16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/5/45 (month) (day) (year)
Cemetery or crematory Clark Chapel Cemetery
Location Harford County Md.
18. Funeral director
Address
19. 9/1 (Date rec'd by registrar) 19 45 Albert R. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 19 45 at 8.05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4, 1945, to Sept., 1, 1945
and that I last saw him alive on September 1, 1945
Immediate cause of death Pulmonary Tuberculosis — DURATION Dec. 1944
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W. Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 9/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

18022

★ Reg. Dist. No. 80

1. PLACE OF DEATH:

County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lillie Foob Woodyard

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: late Aaron W. Woodyard

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 16-1864

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
80	11	4		

9. Birthplace Carroll County Md.

(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business At home

FATHER 12. Name Allen Foob

13. Birthplace Maryland

MOTHER 14. Maiden name Maria Colbert

15. Birthplace Maryland

16. Informant Ruth Woodyard

Address New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 23-1945 (month) (day) (year)

Cemetery or crematory Western Chapel Cem.

Location near Westminster, Md.

18. Funeral director H. H. Hartlove & Sons

Address Union Bridge New Windsor Md.

19. Sept 23 19 45 (Date rec'd by registrar) Grace E. Bucher Asst Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20. 19 45 at 7:25 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 29, 1945 to Sept 20, 1945 and that I last saw her alive on Sept 19, 1945

Immediate cause of death	DURATION
Cancer of stomach	2 yrs +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Reese Wilkens M. D. or other

Address Westminster Date signed 9/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

8923

Reg. Dist. No. 77

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Carroll

City or town: Greenmount Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Greenmount Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ida May Yingling

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: James T. Yingling

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 18, 1871

8. AGE:

Years	Months	Days	If less than one day
74	7	10	hrs. min.

9. Birthplace: Hampstead Md (town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Works at home

FATHER

12. Name: Michael L. Billhart

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mandilla C. Hoover

15. Birthplace: Maryland

16. Informant: Mrs. Carroll Hunt

Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-1-45 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Greenmount, Md

18. Funeral director: Jacob Wilhelm Sons

Address: Manchester Md

19. Sept. 30 1945 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 28 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 12, 1945 to Sept 28 1945 and that I last saw h.er alive on Sept 27 1945

Immediate cause of death	DURATION
Carcinoma of Stomach	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Joseph E. Buck M.D. M. D. or other

Address: Hampstead Md Date signed 9/28/45